Exhibit A

FRAUD WARNING: Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act. For residents of the following states, please see the reverse side of this form: ***California, Colorado, District of Columbia, Florida, Kentucky, Maryland, Minnesota, New Jersey, New York, Oregon, Pennsylvania, Tennessee, Texas or Virginia.***

Name: JANE PATRICIA BARNES	**Social Security No.:** [redacted]
Address: 3481 Euclid Ave Concord, CA 94519	**Telephone No.:** 925-671-9197

1. In your own words, tell us why you cannot work in your own or in any occupation.
My low back and tailbone cause me so much pain that it interferes with my ability to sit, concentrate, focus, or follow-through on a daily basis. I suffer from regular headaches, leg pain, butt pain & an irritated bowel which make it difficult to attend to any regular employment.

2. What is primary physical and/or mental condition preventing you from working now?
Chronic pain syndrome; sciatica; degenerative lumbar/cervical disc disease; neuropathic pain; post L5/S1 microdiscectomy and post anterior L5/S1 fusion; post five-level IDETT; irritable bowel syndrome; dislocated tailbone; dislocated knee cap (R);

3. Can you drive? ☒ Yes ☐ No How far? as needed; to doctors - with increased pain.
↳ usually only errands close by.

4. What time do you get up in the morning? 9-10 am What time do you go to bed? 10-11 pm

5. Where do you live? ☐ Apartment ☒ House
How many floors in the apartment/house? 1 Does it have an elevator? ☐ Yes ☒ No
Do you use any special equipment - ramps, handrails, wheelchair? ☐ Yes ☒ No
If yes, describe ______

6. How often do you use the computer? as needed for personal banking; daily or almost daily
What computer programs or software can you use? Microsoft Office, Word, Excel, a wide range.

7. Check the things you do regularly:

(most activity causes increased pain so I try to minimize by taking breaks)

Activity	Hours per day?	Days per week?
☑ Cook	1 hr	4 to 5
☑ Clean	0-15 min	2 to 3
☑ Shop	0-30 min	1 to 2
☑ Laundry	0-30 min	1
☑ Yardwork	15-30 min	3 to 4 light only
☑ Gardening	15-30 min	4 to 5 light only
☐ Read	1 hr	daily
☐ Watch TV	2 hr	4 to 5
☐ Other (school, attend religious services, volunteer work, etc.) Rest/ [illegible]	1 to 2 hr	daily

What do you do for recreation? [illegible] with [illegible] friends, gardening, go [illegible] with friends

8. Are there things you attend to with regard to your personal needs (grooming, dressing, etc.)?
I shower as needed; I get dressed daily; I take my medicines/vitamins daily; I infrequently use make up; I get by

9. Do you go for walks? ☒ Yes ☐ No [illegible] How often? almost daily with occasional missed days
How far do you walk? [illegible] For how long? 20-40 min [illegible] tailbone and back

10. Do you engage in a regular exercise program? ☒ Yes ☐ No — I TRY TO
Where (home, gym, etc.) local dog park for walk; community pool for swimming
How often? walk daily usually I swim two times per week when possible
Describe your exercise program walk daily & work some swimming weekly
I also have therapeutic bodywork about once per week

11. Please circle the highest grade you completed in school:

1 2 3 4 5 6 7 8 9 10 11 12 GED High School Diploma

College? 1 yr. 2 yrs. 3 yrs. 4 yrs. BA/BS Degree Masters Degree Other

Type of degree? (Business, History, Social Sciences, etc.) BS, MS, PhD
Date Received '79, '81, '85 → BS-Agriculture, Horticulture MS & PHD.
List any professional/educational certificates, licenses, etc. awarded —

List any vocational programs you have attended/completed —

In the last 3 years, what type of certificates or licenses have you received? —

12. Are you taking any professional/educational/vocational classes now? ☐ Yes ☒ No
Please list them

13. Are you working? ☐ Yes ☒ No
If so, please list how many hours per day you work, and the name of your employer.

14. Have you discussed return to work with your physician? ☐ Yes ☒ No
What does your physician say about returning to work? we have not discussed in last yrs

15. When do you expect to return to work? unsure if ever will be able
Will you return to your regular occupation? ☐ Yes ☒ No If no, why not? not available; not able to due to pain
Will you return to Modified job? ☐ Yes ☐ No If no, why not? not available; not physically able

16. Do you know of any positions within your company that you would be interested in? ☐ Yes ☒ No
If yes, what position? company terminated me & eventually closed site;

17. If unable to return to regular position, would you be interested in exploring your career options? ☐ Yes ☒ No
I have already explored options with worker compensation.

Employment History

1. Job Title: PRINCIPAL Research Chemist	Employed date: From: 97 Through:
Major Duties: Complete Routine Studies for FDA submission	Minor Duties: Quality assurance, training
Tools/Equipment used: computer, HPLC, GC, balance etc	Machinery/Computers used: computer IBM
2. Job Title: Principal Research Biochemist	Employed date: From: 93 Through: 94
Major Duties: Team leader, study director supervise	Minor Duties: train,
Tools/Equipment used: All Chromatography stuff, computer	Machinery/Computers used: IBM computer
3. Job Title: Senior Research Biochemist	Employed date: From: 90 Through: 92
Major Duties: Team leader/ study director	Minor Duties: train, teach dietitian
Tools/Equipment used: all lab equipment	Machinery/Computers used: IBM computer

18. Have you ever owned or operated your own business? ☐ Yes ☒ No
Do you own, operate or have ownership interest in a business now? ☐ Yes ☒ No
Business Name

19. Are you married, or do you have a domestic partner? ☒ Yes ☐ No married 10/22/04
Do you have any children under age 25? ☒ Yes ☐ No Stepdaughter-20
Do you have any handicapped children (regardless of age)? ☐ Yes ☒ No
If you answered "Yes" to any of the above questions, please list below.

NAME	RELATIONSHIP	GENDER (M/F)	DATE OF BIRTH	SOCIAL SECURITY NO.
1. Victor Rodrigues	husband	☒ M ☐ F	9/16/1957	
2. Veronica Rodrigues	step-daughter	☐ M ☒ F	12/27/1984	
3.		☐ M ☐ F		
4.		☐ M ☐ F		
5.		☐ M ☐ F		

20. List any prescription medications you take: Use other side if you need more space. — see extra sheet

	Medication	Dose	Frequency		Medication	Dose	Frequency
1	OXYCONTIN	3-40 mg	3 times/day	4	Ambien	10 mg	nightly
2	NORCO	10 mg	3-4 per day	5	Toprol	?	daily
3	Effexor XR	150 mg	nightly	6	Provigil	200 mg	daily

see extra sheet

21. List any doctor(s) you see regularly. Use the other side if you need more room.

Doctor's Name/Speciality: MD, MBA, CHE, FRCPC. DR Mannie Joel, Pain Managment	Doctor's Name/Speciality: DR Fillmore MD; Elizabeth Guzman RN, NP - Gyno (ob/)
Address: 1500 East 14th Street San Leandro, CA 94578	Address: 2999 Bacon St Ste 1 Concord CA 94596
Telephone #: 510-734-0226 / Fax #: unknown (my sept appt is rescheduled for Nov 7)	Telephone #: 925-676 3450 / Fax #: don't have it
Frequency of visits: Quarterly (usually) / Date of last visit: June (the 7th)	Frequency of visits: Should be Once per year / Date of last visit: Oct 2005 (missed 2004)
Doctor's Name/Speciality: DR John Toth, D.O, GP	**Doctor's Name/Speciality:** DR Wolfe - GI
Address: 2270 Bacon St Concord CA 94520	**Address:** He prescribe my GI related meds but I have not seen him recently - he had lack surgery
Telephone #: 925-687-9447 / **Fax #:** 925 687 9483	**Telephone #:** 510 460-0246 OR 415 550 1700 / **Fax #:**
Frequency of visits: when I have issues / **Date of last visit:** Oct 2004	**Frequency of visits:** Irregular but (Regular med review) / **Date of last visit:** a few years ago (colonoscopy & esophageal test)

22. Are you right handed or left handed? ☒ Right ☐ Left
What is your height? 5' 7 inches
What is your weight? 215 lbs
What is your date of birth? June 13, 1957

23. Are you a veteran? ☐ Yes ☒ No
If yes, have you applied for VA benefits for this disability? ☐ Yes ☐ No
Please attach a copy of your VA disability award.

24. What other types of income/money/compensation/benefits are you receiving or eligible to receive?

			$ Amount/Frequency	Date Began	Date Paid Through
☐ Yes	☒ No	Salary Continuance			
☐ Yes	☒ No	State Disability Benefits			
☐ Yes	☒ No	Group Disability Benefits	NOTE: Social security rate is different each year; $1532	rate is different each only since Jan 05.	
☐ Yes	☒ No	Workers' Compensation			
☐ Yes	☒ No	Pension Benefits			
☒ Yes	☐ No	Social Security Disability Benefits	$1532/mo	12/17/98	10-19-05
☐ Yes	☒ No	No-Fault Auto Disability Insurance			
☐ Yes	☐ No	Any Other Disability Income			

I certify that the information in this document is true and correct.

Signature Jose Rodrigues Date Oct 20, 2005

Exhibit B

FRAUD WARNING: Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act. For residents of the following states, please see the reverse side of this form: ***California, Colorado, District of Columbia, Florida, Kentucky, Maryland, Minnesota, New Jersey, New York, Oregon, Pennsylvania, Tennessee, Texas or Virginia.***

ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY (PLEASE PRINT)

The insured is responsible for having this form completed by any/all treating physician(s) without expense to the company. We must have comprehensive medical information in order to evaluate the insured's claim for Disability Benefits.

THIS SECTION IS TO BE COMPLETED BY THE PATIENT/INSURED

1. NAME Jane Patricia Barnes		EMPLOYER NAME Was Bioscience Ag Products
ADDRESS 3481 Euclid Ave		SOCIAL SECURITY NUMBER [redacted]
CITY Concord	STATE CA ZIP CODE 94519	GROUP POLICY NUMBER
TELEPHONE 925 671 9197	OCCUPATION Was Scientist	DATE OF BIRTH 6-13-1957

THE REMAINING SECTIONS OF THIS FORM ARE TO BE COMPLETED BY YOUR PHYSICIAN(S)

1. DIAGNOSIS (Including any complications)

(a) Diagnosis (Include ICD-9 or DSM-IV Code) Multi level lumbar disc disease 722.52
Cervical disc disease 722.4

(b) Subjective symptoms Pt can not sit for prolonged periods of time. When the pt tries to carry light load, she feels immediate pain in her back.

(c) Objective findings (Please attach copies of current X-rays, EKG's, Laboratory Data and any clinical findings as applicable.)
B/L. pain in buttocks, exquisite tenderness over coccyx area. Pt can not sit, Sciatic nerve pain, (+) Lasegue's sign, scoliosis (+) to SC

(d) Are symptoms consistent with the clinical findings? ☒ Yes ☐ No, explain _____

(e) Is illness work related? ☒ Yes ☐ No

(f) If pregnancy please indicate: LMP: _____ EDC: _____ Actual Delivery: _____

2. DATES OF TREATMENT

- Date patient first visited you for this accident/illness: Month 7 Day 14 Year 1999
- Date patient first unable to work due to this accident/illness: Month Day Year Pt was intermittently disabled
- List frequency & date(s) patient was examined for this accident/illness: every 2-3 days
- Date of last visit: Month 12 Day 20 Year 05 2nd MD office

3. NATURE OF TREATMENT (Including Surgery & Medications prescribed, if any)

Hospitalization on: Month Day Year THROUGH Month Day Year

- Surgery on: Month Day Year Type of Surgery:

Name and Address of Hospital

- Medications-type/dosage:

- Medications-type/dosage:

4. PHYSICAL LIMITATIONS / IF APPLICABLE: In an 8 hour day is your patient able to:

	0 hours	up to 2.5 hours	up to 5.5 hours	greater than 5.5 hours
Climb	☐	☐	☐	☐
Balance	☐	☐	☐	☐
Stoop	☐	☐	☐	☐
Kneel	☐	☐	☐	☐
Crouch	☐	☐	☐	☐
Crawl	☐	☐	☐	☐
Reach	☐	☐	☐	☐
Walk	☐	☐	☐	☐
Sit	☐	☐	☐	☐
Stand	☐	☐	☐	☐

Cardiac - If applicable (American Heart Association)

- ☐ Class 1 - No Limitation
- ☐ Class 2 - Slight Limitation
- ☐ Class 3 - Marked Limitation
- ☐ Class 4 - Complete Limitation

Blood Pressure (last visit) _____

ptd permanently disabled

Please indicate the maximum level of ability (sedentary, light, medium, heavy) of your patient to:

_____ Lift _____ Carry _____ Push _____ Pull

Sedentary = 10 lbs. maximum, walking occasionally. **Light** = 20 lbs. maximum, 10 lbs. frequently
Medium = 50 lbs. maximum, 25 lbs. frequently, up to 10 lbs. constantly. **Heavy** - 100 lbs. maximum, 50 lbs. frequently, 20 lbs. constantly.

5. MENTAL IMPAIRMENT / IF APPLICABLE: Please complete the following (incomplete information will delay claim processing):

Axis I: _____

_____

II: _____

III: N/A

IV: _____

V: Current GAF: _____ Highest GAF in past year: _____

Additional Comments:

6. RETURN TO WORK STATUS

	Patient's Regular Occupation	Any Occupation
When was patient able to go to work?	permanently Disabled (Month Day Year)	Month Day Year

7. REHABILITATION

(a) Is patient a suitable candidate for further PHYSICAL / PSYCHOLOGICAL rehabilitation services? ☐ Yes ☒ No

If no, explain: _____

8. REMARKS

DATE 11-3-05	PRINT NAME (ATTENDING PHYSICIAN) Marnie Joel MD	SIGNATURE	DEGREE MD
TELEPHONE NUMBER 510 278-0026		PROVIDER TAX ID NUMBER 941981772	
STREET ADDRESS 15035 E. 14th St.			
CITY OR TOWN San Leandro		STATE (OR PROVINCE) CA	ZIP CODE 94578